Anna Kotlarska-Michalska
Institute of Sociology
Adam Mickiewicz University, Poznań

Limited public and private space for Polish retirees

Streszczenie

Limitowana przestrzeń publiczna i prywatna polskich emerytów

W artykule przedstawione zostały przykłady zjawiska limitowania przestrzeni społecznej osobom w starszym wieku. Zjawisko to przybiera postać ukrytej dyskryminacji, a jej występowanie wobec polskich emerytów jest szczególnie wyraźne w tak ważnych rolach, jak: rola pacjenta, pracownika i konsumenta usług opiekuńczych. W artykule przyjęto, że limitowanie przestrzeni jest uzurpowaniem sobie prawa przez instytucje, zbiorowości społeczne, grupy społeczne czy kręgi społeczne do rozstrzygania o zakresie swobody innych jednostek. Limitowanie roli społecznej to ograniczanie komuś możliwości wyboru roli oraz dyktowanie jej zakresu. Limitowanie przestrzeni w graniu roli społecznej, to dzielenie się przestrzenią (rozumianą jako aktywność, role, funkcje, zadania itp.) w sposób nie zawsze sprawiedliwy i nie zawsze uzasadniony. W przypadku osób w starszym wieku, ograniczanie dotyczy tych sfer życia, do których pragnęłyby one mieć szerszy dostęp, ze względu na specyficzne potrzeby związane z kondycją psychofizyczną oraz wynikające z ich statusu ekonomicznego.

Słowa kluczowe:

dyskryminacja, limitowanie praw, ograniczanie wyborów życiowych

Abstract

This article presents selected examples of the phenomenon of limiting social space for elderly people. This phenomenon takes the form of covert discrimination. Discrimination against Polish retirees is particularly evident in relation to such important roles as the role of the patient, employee, and social care client.

Key words:

discrimination, limiting someone's rights, limiting the possibilities for playing social roles

The main aim of this paper is to present manifestations of the phenomenon of setting limits on what social roles ageing people can assume and of "designating" space for the elderly, who are considered to be representative of a passive generation which is, stereotypically speaking, less able to take on roles and enter domains that are reserved for other age groups. The modest scope of this paper makes it impossible to discuss or document all manifestations of limitations placed on the elderly with regard to the space that is available to them. Therefore, of necessity, the text only presents those which are particularly severe for ageing people and also, in their opinion, unjust.

Limiting this space can also be understood as limiting the possibilities for playing certain social roles, i.e. those which one wants to play and which are compatible with the needs that are specific to a given age group; for example, the role of a recipient, consumer, petitioner, beneficiary, and viewer. Such limitations may also be accompanied by a reluctance to "share a space" related to playing social roles that are a sign of one's social position and prestige, such as the role of an architect, producer, decision-maker, and actor. The above-mentioned roles are only examples of social and private roles; they have been deliberately juxtaposed and presented as polar opposites according to the level of activity they entail.

Limiting this private space can also be understood as defining the limits of "decency" and limiting the possibilities of deciding one's own fate independently. Limitations can also be placed with regard to assuming particular roles in marriage and family as well as to making decisions which are "subject to the opinions" of other family members. Generally speaking, limited space in private and public domains means limited possibilities for satisfying one's needs, restricted access to particular services, and deciding for an individual or a group about their rights and their degree of access to certain forms of social activity. Restricting space for someone in social terms amounts to the usurpation by institutions, social communities and groups or social circles of the right of other individuals or groups to decide on their rights. Limiting the possibilities for someone to take particular social roles also means limiting the choice and defining the scope of opportunities that can be made available to that person according to those who impose said limits. This can also be effected by sharing social space (which is understood as activities, roles, functions or tasks, etc.) in a way that is not always fair and not always justified. As for elderly people, such limitations may be related to those spheres of life to which they would like to gain better access because of their specific needs that are connected with their psychological and physical state, as well as their economic status.

The phenomenon of limiting such space can be associated with discrimination against and the stereotyping of ageing people, which is referred to in the relevant literature as ageism (Stypińska 2010) – the "right" to limit the possibilities for someone to actively play multiple social roles results from stereotypical notions about human capabilities at a given age. This can be seen in the way in which employers, doctors and social politicians behave, as well as in intergenerational relations.

It is also worth taking a closer look at restricted access to various institutions, venues and organizations from the perspective of elderly people's self-limitation – limitations which are caused by stereotypical notions such as: "it's not proper", "it's no longer appropriate at my age", "what will others say?", "you cannot expose yourself to ridicule", etc. Such self-limitation is the consequence both of fear of a negative social reaction and of an acceptance of stereotypes as norms that define the extent to which it

is desirable for someone to take on particular social roles at a given time. The roles that are regarded as suitable for elderly people entail having fun and enjoying life in moderation. Determining the limits of ageing persons' freedom to design their own lifestyle has always been a part of culture and, especially, of social control. In traditional culture, limiting someone's freedom was one of the principles of community life, whereas limiting one's presence in social space was seen as a sign of becoming socialized into the role of an elderly person.

When analyzing the practice of limiting this space, one can adopt at least two theoretical perspectives which will make it easier to utilize facts, namely social control theory and the theory of social marginalization, which assumes that there are several reasons why it is possible to restrict someone's rights. It puts emphasis on instances of such limitations of rights in specific spheres of life. According to T. Kowalak, marginality is a relative concept which requires reference to other social groups. This, however, raises the question of how to establish a point of reference, i.e. a set of social characteristics, in relation to which a given group could be considered marginal. In his opinion one may determine the extent of marginalization based on the degree to which a given person or social group: a) has no power, rights, freedom of choice, access to material and cultural goods, or opportunity to take a rest; b) is forced into something, discriminated against and/or stigmatized; c) is helpless and deprived of help (Kowalak 1998). This conception seems to be general enough to be used for the purpose of analyzing the phenomenon of limiting private and public space with regard to these three dimensions.

When attempting to characterize examples of the marginalization of ageing people several years ago, I pointed out that the process of marginalizing this age group in Poland was unusual in that it was mostly based on a withdrawal from playing particular social roles and an assumption of roles that were unwanted and socially unacceptable. This is especially true of people who have low income, low aspirations, limited opportunities for self-actualization and a limited influence on their own life, as well as those who are not very self-sufficient physically (Kotlarska-Michalska 2009). When analyzing examples of such marginalization at that time, I pointed to those, the validity of which had been confirmed empirically and which were related to areas of social activity where elderly people were simply ignored, such as education, culture, tourism, fashion, entertainment and politics. I presented most of the empirically confirmed examples of discrimination in that article. In this paper, however, I intend to draw attention to other aspects of this phenomenon that are not formally referred to as discrimination, i.e. the causes, development and consequences of limiting this space, which is understood as allowing people to take on specific social roles under certain conditions.

Limiting such space for Polish retirees begins with a considerable reduction of the possibilities of taking on roles that are a sign of one's social position or of being

active on the labour market, which, in turn, is a factor or one of the factors that limit the possibilities for assuming many other roles in social, family and personal life. Therefore, there is a simple mechanism at work here – low social position "transfers" to limited rights in the private space.

Limiting the range of available roles is an example of limiting the possibilities of fully assuming public roles in the social domain, which is evidenced by the results of numerous research studies on young people's attitudes toward sharing their professional roles with the elderly. Unemployment among young people fuels their resentment toward ageing people – the young see the fact that retirees hold down their jobs as a barrier to employment.

This resentment may also be related to the private domain. Although there are no available results of sociological research into the extent to which adult children of ageing parents influence their decisions about marriage, retirees very rarely get married. However, the opinions of the few who reported that they were interested in building a life again with someone indicate that an interfering adult child or children prevent them from making such a decision. This facilitates a tendency for elderly people to enter into informal relationships, which are not particularly well tolerated by their children either. Based on demographic research (Kałuża 2010), it can be said that the percentage of senior newlyweds is constantly falling – it was 0.5% for women and 1.5 for men aged 60 and older in 2008. In absolute terms, there were 6,171 men and 2,615 women aged over 60 among newlyweds in 1970, and only 4,293 men and 2,301 women in 2008 (p. 293). Obviously, the decreasing popularity of formalized relationships among people in this age category may also result from the growing popularity of cohabitation, but the very fact that the rate of formalized relationships is declining allows one to adopt a hypothesis that adult people interfere in their parents' private lives.

As for the private sphere of life, attention should be paid to the ways in which adult children limit the range of roles in the family available to their ageing parents, which the latter are unwilling to admit as they treat it as a kind of educational failure. Adult children's overprotectiveness toward the elderly can manifest itself in their controlling their parents' spending, i.e. dictating the way in which they spend their money or even depriving them of the right to choose what to purchase, for example, by helping them with shopping and, at the same time, making decisions for them. Adult children may tell their parents what food, clothes or other daily necessities they should buy. The few studies that have been conducted on forms of psychological violence against the elderly provide evidence that there are various kinds of domestic, intergenerational relations which show that older people's rights to decide about themselves as well as to self-determination are violated. Limiting elderly people's autonomy is justifiable to a certain extent when they are seriously ill, but it is undoubtedly an instance of violence when this happens in all of the other, unjustified, cases.

The phenomenon of self-limitation on the part of the elderly may be a consequence of realizing that they are unattractive because of a chronic disease. According to Barbara Uramowska-Żyto (1998), some diseases may cause strong social reactions and, as a result, such persons cannot effectively perform their professional and social functions. The stigma of the disease may cause them to become socially withdrawn and push them to the margins of society, where their illness is not seen as strange, whereas their "self" or their "self-image", i.e. the way in which they think they are perceived by others, becomes disintegrated. Thus the whole system of interactions and of symbolic communication with the environment that they know is destroyed, and the effects of the long and complicated process of "finding one's place" in social reality are nullified (p. 84).

Elderly people may also withdraw from social life for many other reasons which are unrelated to their physical state, such as low self-esteem and a sense of having nothing particularly interesting to offer.

Young people see limiting older people's right to play socially attractive roles as something obvious. Elżbieta Czapka's (2007) research shows that young students regard the following activities as the most appropriate for the elderly: taking care of grandchildren, meeting with friends, going to health resorts, working in the garden and going to church. More than half of them (54.8%) were inclined to say that professional work was not among activities that were suitable for ageing people. However, the students take a different attitude toward their own old age, which they perceive as an active period of life, i.e. a time when they will be members of a social group and which will be spent at leisure. At the same time they believe that the elderly should first of all fulfill family-related roles (p. 245). However, studies carried out among small segments of the population do not allow one to make generalizations. There are numerous research studies which show that young students have a favourable attitude toward their own grandparents and they do not succumb to stereotypes about old age (Kosior 2007). Many sociological studies have confirmed that people with higher education show greater tolerance and even have a more favourable attitude toward the elderly.

Examples of limiting the private space of older people can be seen not only in the way in which young people dictate what roles the elderly should assume, but also in the way adult children or grandchildren control elderly people's spending, violate their right to freely express their opinions, impose a given style of clothing especially on older women, control elderly people's social life, which is especially true in the case of older men, limit their right to have a happy personal life (by refusing to accept their partner), reduce their roles as grandfathers and grandmothers e.g. to the role of a carer but not of an educator, determine desirable forms of activity (e.g. gardening), reduce their role to that of the "retiree in the family", limit the range of available forms of cultural activity, set limits to their dreams and plans, and impose rules relating to their physical self-sufficiency and the extent of help provided by family members. Many of

these forms of limitation unfortunately bear the hallmarks of psychological and moral violence, which should be regarded as a special kind of intentional actions aimed at limiting the victim's right to self-determination and autonomy. The issue of violence as a specific type of behavior that restricts another person's freedom needs to be dealt with separately. This is also one of the least explored phenomena – especially because this form of domestic violence is carefully concealed.

Manifestations of a willingness to limit the range of possible roles that can be played by the elderly and to set the limits of "apparent decency" may constitute a method of "manageing" old age which does not take into account elderly people's wealth of knowledge, experience and resources and which reduces wrongly understood care to control over older people's lifestyle as well as interference in the intimate spheres of life, out of a well-intentioned concern for their safety and life quality.

Elderly people are among those who are particularly doomed to have no choice – their disability condemns them to be dependent on the staff of a nursing home or other care facilities, or on a family member who reluctantly performs the role of a caregiver and openly emphasizes the "weight" of this burden. Very often survey reports show that elderly nursing home residents have experienced physical and psychological violence, which can be clearly interpreted as limiting people's right to dignity.

When explaining the causes of limitations imposed with regard to the freedom of decision-making and access to social space, one may want to take into consideration those factors which have always been decisive in determining an individual's position within the family and society, i.e. the social, the cultural, the economic, the personal, and the biopsychological (Kotlarska-Michalska 1987). The importance of these factors may change along with the significance of values that play a dominant role in a given culture and also when values that were at the top of the hierarchy for the previous generation have declined in importance. There is no doubt that contemporary technological advancements and computerization condemn elderly people to dependence on the services rendered by the younger generation, which gives young people who instruct the elderly how to use various objects in this technologized world the right to teach and advise them. This relationship is not always equal – the elderly need technical guidance and assistance from younger people, but the latter do not necessarily want to use outdated instructions from the former on how to live, as such principles are out of date, old-fashioned and unsuitable for young people.

Although there are many papers dealing with examples of discrimination against older people, it is worth paying attention to those which are based on reliable empirical research and which will allow one to make generalizations. Among such important sources there is a report entitled „Stop dyskryminacji ze względu na wiek" (*Stop Age Discrimination*), which was prepared by the Academy for the Development of Philanthropy in Poland. In the introduction to this report, Barbara Szatur-Jaworska (2005)

lists phenomena that can be regarded as sources of discrimination against the elderly: 1) negative stereotypes about old age; 2) the cult of youth in Polish society; 3) the fact that people holding positions of public trust are facing an ethical crisis (e.g. in the medical professions); 4) a lack of reliable knowledge about old age among employers, decision-makers and those who provide various services to the elderly; 5) the growing unemployment rate, which increases competition in the labour market; 6) a shortage of funds allocated for the purposes of social policy and financial shortages in households; 7) a growing number of specific needs of the elderly (related to health and care); 8) the rules and procedures for applying the law (e.g. the adversarial principle in civil law proceedings); 9) procedures for allocating funds to different social assistance organizations (e.g. those obtained from the National Health Fund *NFZ*); 10) low levels of education and loneliness among the elderly, 11) poor work organization in institutions that provide services to elderly people (lack of comprehensive geriatric care) (p. 9).

Experts unanimously point out that age discrimination has many causes. According to Tomasz Schimanek (2005), the primary causes are the following: a low level of awareness and knowledge of the law; a situation in which shortages in one area are compensated for through changes in another area, i.e. high unemployment leads to the dismissal of people aged over 50; and a dynamic development of modern technologies which causes employers to dismiss persons who find it difficult to learn. In addition, the widespread stereotypes about the elderly are also discourageing for employers. T. Schimanek believes that the enormous technological and ownership-related changes in Polish economy are not conducive to the development of master-pupil relationships, which would allow the elderly to share their experience and professional knowledge with junior employees while also upholding a given company's tradition. Another obstacle is special protection against termination of employment for employees who will be entitled to retirement pension in less than four years, which makes employers reluctant to employ persons for whom the protected period has started or will start soon (p. 37). The abovementioned factors cause Polish people who are at pre-retirement age and at early retirement age to be the second most professionally passive population in Europe. According to Eurostat's statistics, Poland is among the countries in which people quit the labour market quite early and find it fairly hard to return. In comparison with other countries (p. 40), only 26.1% of people aged 55–64 are employed in Poland, whereas in the European Union the proportion is 38.7%. Sweden (68%), Denmark (57.9%) and Great Britain (53.5%) are countries with the highest employment rate for this age group (p. 41).

According to Iwona Jaroszewska-Ignatowska (2005) the sources of discriminatory practices used by employers against people at retirement age are the following: the employer can choose an employee; the costs of running a business activity are high; there is a stereotypical image of an employee aged over 50; employers are reluctant to comply with the regulations on the protected period; people looking for a job feel worried

or even afraid that they might not find it if they have filed a case against an employer before. Other sources of discrimination include poor knowledge of the law both among employers and employees, as well as the excessive length of court proceedings (from 1.5 to 5 years). Such practices and phenomena make people reluctant to file a case against their employers, and labour courts are likewise reluctant to adjudicate discrimination complaints (pp. 32–33). Th low penalties for non-compliance with labour laws give employers the freedom to limit the professional opportunities of people approaching or at retirement age.

Health is another very important sphere of life in which the elderly encounter limitations, as evidenced by the facts cited by Jolanta Twardowska-Rajewska (2005). This author, who is a geriatrician by profession, lists many facts which clearly demonstrate that ageing people have difficulty in gaining access to medical examination and treatment. Instances of limitations placed on the elderly with regard to the role of the patient are all too clear. This is caused by several factors: 1) the pressure to economize that is put on doctors forces them to choose whom to treat; 2) an inadequate system of treatment; 3) too little importance is attached to prevention, as a result of which treatment is of remedial character; 4) there is no coherent system of geriatric care; 5) the National Health Fund puts limitations on funds that are allocated to geriatric care. These are the causes of age-related access barriers to medical examinations, preventive programs and medical procedures and limited access to prostheses and rehabilitation equipment. In accordance with the Ordinance of the President of the National Health Fund, there is an age-related access barrier to preventive health examinations. For example, women aged 25 to 59 can undergo free Pap tests, women aged 50 to 69 can benefit from the program of early breast cancer detection, people aged 50–65 can have a colonoscopy done free of charge, and people aged 40–65 are eligible for free spirometry.

The number of referrals to specialists carrying out such tests is also limited, which is evidenced by facts known from medical practice. J. Twardowska-Rajewska points out that she has seen (during her practice as a geriatrician) doctors refusing referrals to specialists who carry out preventive medical examinations and presenting arguments such as "at this age it does not matter anymore, and young people should be treated first", whereas a request for a gynecological examination or an examination of the breasts is met with surprise or even disgust on the part of the doctor (p. 51). Such limitations concern all areas of medical treatment, including oncology. For example, it is recommended that the use of new-generation medicines by patients aged over 65 who suffer from colorectal cancer should be limited (p. 52). Doctors in hospitals also often refuse, or are unwilling, to perform stenting, ballooning and coronary artery bypass grafting. Furthermore, they are reluctant to perform oncological surgery on ageing patients, even if there are no cardiac contraindications. Another example of limits placed on medical services available to the elderly is that, even though doctors should carry out surgical treatment to fix a femoral

neck fracture within one day of its being broken, they use maintenance treatment even when there are no contraindications to surgery. As J. Twardowska-Rajewska says, doctors also sometimes refuse to apply intramedullary fixation or to perform arthroplasty, and they directly suggest that a patient should get a prosthesis from a private medical facility (walkers, crutches, dentures, and hearing aids). It is also difficult for ageing people to gain access to physical therapy and rehabilitation (p. 52).

Geriatricians' stance on this issue is that it is an undeniable fact that the Polish health care system discriminates against people on the grounds of age. They unanimously state that this phenomenon is caused by the insufficient number of geriatricians in Poland (there is not a single geriatrician in four provinces, and the rate of geriatricians per 10,000 inhabitants is less than 1, i.e. usually from 0.3 to 0.8 per 10,000 inhabitants, with the exception of one province). This is why there are so few geriatric outpatient clinics and, consequently, it is difficult to assess an elderly patient's health (Rajska-Neuman 2005). Furthermore, primary care physicians are insufficiently educated in geriatrics. There are also no prevention programs for elderly people (p. 54). Another factor contributing to the difficulties in providing geriatric care – which has been repeatedly pointed out by geriatricians – is that the National Health Fund does not stipulate the time of a doctor's visit in geriatrics in medical contracts. Aaccording to health care standards adopted for this medical specialty, the first visit should last 60 minutes and a follow-up doctor's visit should be 30 minutes long. These standards, however, do not translate into reimbursements from the National Health Fund, and the higher costs of treating senior patients are not taken into account as far as hospital care is concerned (p. 55). The stipulation that a 1.5 conversion factor should be used for this group of patients with regard to hospital care services remains ignored. It turns out that the methodology of providing health care services does not take into account ageing patients with multiple morbidities, and the National Health Fund's rules pertaining to contracts do not provide for the multiple treatments that are typical of geriatrics. Also, cancer diagnostics has not been included in the range of geriatric treatment services (p. 56). The cited text also points out that geriatric units are closing down and the number of beds in the existing units reduced, even as the number of patients is growing – which reduces treatment time. What is of utmost importance is the issue of palliative care for patients whose causal treatment has been completed and who can only undergo symptomatic treatment (p. 57). According to a consultant geriatrician, there are only 684 beds in geriatric units in Poland, and the number should be 7,000. Indirect forms of providing geriatric care are, obviously, another example of the lack of imagination on the part of the National Health Fund's decision-makers and show that the access barriers to health care (lack of medical care provided by doctors and nurses) are a textbook case of limits on ailing people's right to treatment. The stance presented by the College of Physicians Specializing in Geriatrics (*Kolegium Lekarzy Specjalistów Geriatrii*), which is based on reliable diagnosis, is yet

to be considered. The above-mentioned data, which confirm the fact that both formal and informal limitations are imposed on elderly patients, show that it is easy to document or even explain the phenomenon of limits on the possibilities for ageing people with regard to the role of the patient.

Limits on the space for the elderly as beneficiaries of social assistance programs is another example of the widespread phenomena of restrictions on ageing people's rights. This is emphasized by Barbara Szatur-Jaworska (2005), who lists several noticeable examples of age discrimination in this sphere of life, including the fact that the needs of the elderly are marginalized by local governments, which is why the funds for this purpose are severely limited and care services are underfunded. The low-income threshold causes the number of social assistance clients to steadily decline, even though the number of ageing people is growing. The elimination of benefits for unemployed spouses who are incapable of working has worsened the financial situation of the elderly. The income threshold is established without taking the prices of medicines into consideration. The elderly also have limited access to social reintegration programs, which are intended for people of working age and not for people of retirement age. Limited access for ageing persons to social welfare centres also results from the location of these institutions and a reluctance to fill out complicated forms and to be carefully examined by social workers. Generally speaking, elderly people are clearly discriminated against in their role as social assistance beneficiaries.

When analyzing the phenomenon of limiting public space, which is important from the perspective of the idea of social integration, it is worth paying attention to the main barriers to participation in society. The authors of the report entitled „Stop dyskryminacji ze względu na wiek" (*Stop Age Discrimination*), which has been cited here many times, point out several basic barriers that are manifested as: 1) difficulties concerning ageing people's participation in elections; 2) a lack of understanding on the part of local authorities for the need to support elderly people's activity; 3) a lack of mechanisms for consulting the elderly community on local governments' decisions; 4) a lack of an appropriate channel for providing information about local matters to older people; 5) limited access to the internet (p. 59). The authors do not treat these barriers as discrimination, but as an obstacle. However, regardless of how one defines this phenomenon, such barriers are undoubtedly a manifestation of limiting the public space for the elderly, especially with regard to the roles of the voter, consultant and architect of a given community.

In the course of analyzing limitations concerning public space one can also point to examples which have been empirically confirmed. As surveys conducted by the Academy for the Development of Philanthropy in Poland (Łuczak 2005) show, people at retirement age do experience and notice discrimination. Such discrimination manifests itself, for example, as unequal treatment (which has been reported by 58% of respondents), disregard and indifference (83%), unpleasant jokes (60%), financial exploitation (27%),

threats and intimidation (23%) and physical violence (13%). Almost one in four people has been treated inappropriately. Among the spheres of life in which they experienced less favourable treatment on grounds of age, the respondents mentioned public transport (51%), health care centres (45%), offices (44%), the street (35%), family (20%), and stores (19%) (p. 94). They also reported difficulties in accessing health care services – 40% were denied the possibility of undergoing a medical examination, 38% were met with disregard, 8% were denied medical assistance, and 5% were diagnosed as "ageing" when they asked for the causes of their ailments (p. 95).

The results of the survey on ageism and age discrimination show that seniors in Poland feel that they are treated as inferior citizens both in private and social life. As for the immediate social environment, this is manifested as disregard, indifference, unpleasant jokes, financial exploitation, threats and intimidation, or even physical violence. However, in the sphere of public life, ageing people mostly experience discrimination on public transport, in health care centers, in offices, on the street, in stores and in the workplace (Stypińska 2010). Among the sources documenting discriminatory practices against seniors it is worth mentioning the results of a study on job advertisements which was carried out by the Polish Society of Anti-Discrimination Law. It turned out that age was the second most common factor after sex, based on which employers used discriminatory practices as early as at the recruitment level (Stypińska, 2010). Research carried out among activists from seniors' organizations aged 50 years and older in eight Polish cities indicate that half of the respondents believe that seniors feel discriminated against in Poland, both in private and social life, which is mainly manifested in a lack of respect. These studies clearly show that the respondents themselves have experienced many different forms of unequal treatment in their environment and, therefore, their opinions are not based on stereotypes but on facts (Stypińska 2010). The results of other studies concerning this phenomenon, i.e. those conducted by Sylwia Kropińska and Katarzyna Wieczorkowska-Tobis (2010), show that as many as 47% of respondents were treated dismissively by a doctor and experienced inappropriate treatment in the hospital, and 17% were discriminated against because of their age.

It is not only procedures for medical services but also doctors themselves that limit the possibilities for the elderly to decide about their own health and treatment methods – very often doctors make it easier for immediate family members to decide to drop the burden of responsibility for sustaining the life of a terminally ill patient. In their article, which deals with this issue, Michał Nowakowski and Luiza Nowakowska (2010) point out that the medicalization of old age and the fact that the management of the "problem" of old age is regarded as the key role of medicine, which has a strong influence on how old age is perceived by society, reduce the experience of ageing to personal contact with a doctor and determine elderly people's system of beliefs, which is also reinforced by family and friends. According to the above-mentioned authors,

the biomedicalization of ageing often causes people to put the blame for social and demographic consequences of population ageing on the elderly.

As can be seen from sociological, educational, socio-medical and economic research, the phenomenon of limits on public space is an unpleasant experience for the elderly. There is much evidence that access for elderly people to social services has been officially restricted for several years. Access to medical and rehabilitation services is also statutorily and customarily limited. The area of medical services for ageing people is a particularly notable example of a stereotypical attitude toward the elderly on the part of doctors as well as of the influence of medicalization as understood in economic terms. However, limiting seniors' right to respect and dignity is the most distressing manifestation of such limitations. This is because they have been brought up to believe in such values. Therefore, it must be difficult for them to understand and accept the fact that they are made to occupy an inferior position in society.

The modest scope of this paper made it impossible to present a more in-depth discussion of the analyzed issue, together with its causes, manifestations and consequences. While the causes of limiting such space are already relatively well understood, the consequences of this phenomenon require further, more in-depth research.

References

Czapka, Elżbieta. 2007. „Społeczne role ludzi starych w świadomości młodzieży. Komunikat z badań", in B. Bugajska (ed.), *Życie w starości*. Szczecin: Wydawnictwo ZAPOL.

Jaroszewska-Ignatowska, Iwona. 2005. „Dyskryminacja osób starszych ze względu na wiek na rynku pracy – aspekty prawne", in B. Tokarz (ed.), *Stop dyskryminacji ze względu na wiek***.** Warszawa: Akademia Rozwoju Filantropii w Polsce.

Kałuża, Dorota. 2010. „Nowożeńcy w *późnym wieku* w Polsce" in D. Kałuża, P. Szukalski (eds) J*akość życia seniorów w XXI wieku z perspektywy polityki społecznej*. Łódź: Wydawnictwo Biblioteka.

Kosior, Monika. 2007. „Kontakty międzypokoleniowe a postrzeganie seniorów przez ludzi młodych. Komunikat z badań", in: B. Bugajska (ed.), *Życie w starości.* Szczecin: ZAPOL.

Kotlarska-Michalska, Anna. 2009. „Przejawy marginalizacji i wykluczenia ludzi starych", in K. Podemski (ed.), *Spór o społeczne znaczenie społecznych nierówności*. Poznań: Wydawnictwo Naukowe UAM.

Kotlarska-Michalska, Anna. 1987. „Czynniki wpływające na pozycję człowieka starego w rodzinie" *Ruch Prawniczy, Ekonomiczny i Socjologiczny*, 1.

Kowalak, Tadeusz. 1998. *Marginalność i marginalizacja społeczna*. Warszawa: Dom Wydawniczy Elipsa.

Kropińska, Sylwia and Katarzyna Wieczorkowska-Tobis. 2010. „Dyskryminacja ze względu na wiek w ochronie zdrowia w opinii seniorów", in D. Kałuża, P. Szukalski (eds) *Jakość życia seniorów w XXI wieku z perspektywy polityki społecznej*. Łódź: Wydawnictwo Biblioteka.

Nowakowski, Marek and Luiza Nowakowska. 2010. „Medykalizacja starości: dylematy i zagrożenia", in D. Kałuża, P. Szukalski (eds) *Jakość życia seniorów w XXI wieku. Ku aktywności*. Łódź: Wydawnictwo Biblioteka.

Łuczak, Beata. 2005. „Dyskryminacja ze względu na wiek w oczach ludzi starszych. Prezentacja wyników badania przeprowadzonego przez Forum 50+. Seniorzy XXI wieku", in B. Tokarz (ed.), *Stop dyskryminacji ze względu na wiek*. Warszawa: Akademia Rozwoju Filantropii w Polsce.

Rajska-Neumann, Agnieszka. 2005. „Stanowisko Kolegium Lekarzy Specjalistów Geriatrii w Polsce w sprawie dyskryminacji osób starszych w sektorze ochrony zdrowia w Polsce", in B. Tokarz (ed.), *Stop dyskryminacji ze względu na wiek*. Warszawa: Akademia Rozwoju Filantropii w Polsce.

Stypińska, Justyna. 2010. „Warunki Pan spełnia, tylko PESEL nie ten" – czyli o zjawisku ageismu we współczesnej Polsce", in D. Kałuża, P. Szukalski (eds), *Jakość życia seniorów w XXI wieku z perspektywy polityki społecznej*. Łódź: Wydawnictwo Biblioteka.

Szatur-Jaworska, Barbara. 2005. „Wprowadzenie", in: B. Tokarz (ed.), *Stop dyskryminacji ze względu na wiek*. Warszawa: Akademia Rozwoju Filantropii w Polsce.

Szatur-Jaworska, Barbara. 2005. „Dyskryminacja ludzi starszych ze względu na wiek w obszarze pomocy społecznej", in B. Tokarz (ed.), *Stop dyskryminacji ze względu na wiek.* Warszawa: Akademia Rozwoju Filantropii w Polsce.

Schimanek, Tomasz. 2005. „Aktywność zawodowa osób starszych w kontekście problemu dyskryminacji ze względu na wiek na rynku pracy", in B. Tokarz (ed.), *Stop dyskryminacji ze względu na wiek*. Warszawa: Akademia Rozwoju Filantropii w Polsce.

Tokarz, Beata. 2005. „Postawy wobec starości i ludzi starszych", in B. Tokarz (ed.), *Stop dyskryminacji ze względu na wiek.* Warszawa: Akademia Rozwoju Filantropii w Polsce.

Twardowska-Rajewska, Jolanta. 2005. „Dyskryminacja ze względu na wiek w obszarze ochrony zdrowia" in B. Tokarz (ed.), *Stop dyskryminacji ze względu na wiek.* Warszawa: Akademia Rozwoju Filantropii w Polsce.

Uramowska-Żyto, Barbara. 1990. „Socjologiczne koncepcje zdrowia i choroby", in A. Ostrowska (ed.), *Wstęp do socjologii medycyny*. Warszawa: Wydawnictwo IFiS PAN.